**MISSOURI DEPARTMENT OF MENTAL HEALTH**

DORN SCHUFFMAN, DEPARTMENT DIRECTOR

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| CHAPTER | SUBCHAPTER | EFFECTIVE DATE | NUMBER OF PAGES | PAGE NUMBER |
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| SUBJECT | AUTHORITY | HISTORY |
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| Use of Seclusion and Restraint | 630.050 and 630.175 | See below |

| PERSON RESPONSIBLE | SUNSET DATE |
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| Director CPS | June 31, 2008 |

**PURPOSE:** Prescribes the policy on the use of seclusion and restraint.

**APPLICATION:** Applies to the Division of Comprehensive Psychiatric Services (CPS) Adults and Children's Psychiatric Facilities.

(1) This DOR applies to the Division of Comprehensive Psychiatric Services Adult and Children's facilities accredited by the Joint Commission on Accreditation of Health Care Organizations except in the following specific situations.
   (A) Forensic restrictions and restrictions imposed for security purposes by law enforcement or by facility security staff (e.g., use of security devices for transportation outside a locked unit and/or outside the facility for individuals who are EITHER on police/sheriff hold status OR who are involuntarily committed and at risk of eloping during transport out of the facility for court hearings or medical appointments) OR while awaiting transfer to intermediate or maximum security environments in the Guhleman or Biggs Forensic Centers).
   (B) Physical holds of children for safety reasons such as holding a hand as the consumer crosses a street.
   (C) Procedures specific only to the Biggs Forensic Center (Maximum Security) regarding the maintenance of a security environment equivalent to that of a jail or correctional setting for an individual transferred to these settings whose legal status is that of jail detainee, correctional inmate, or pre-trial evaluation. All other applications of this DOR apply.
   (D) Facilities may delegate the written order for seclusion or restraint to an Advance Practiced Nurse, privileged by the facility for that function.
   (D) The Cottonwood Residential Program and the Missouri Sexual Offender Treatment Program are to develop Restraint and Seclusion Policies specific to their facilities for review and approval by Medical Director for Department of Mental Health and the Division Director for Comprehensive Psychiatric Services.

(2) This DOR is modified in the following specific situation:
   (A) Facilities may delegate the face to face clinical assessment for seclusion or restraint to an Advance Practiced Nurse, privileged by the facility for that function. Should facilities so utilize an Advance Practice Nurse, a determination of whether the intervention is imminently necessary for protection of health and safety and that it is the least restrictive alternative shall be obtained verbally from either the attending physician or the head of the facility and shall be

documented by the Advanced Practice Nurse in the medical record at the time the order is written.

(3) PHILOSOPHY. The leadership of Department of Mental Health recognizes that the use of restraint and seclusion poses an inherent risk to the physical safety and the psychological well-being of both individuals and staff. In particular, while some of the individuals we serve have high rates of violence toward themselves and others, there is recognition that many of the individuals we serve have also had a high incidence of exposure to sexual, physical and emotional abuse. Consequently, we recognize that any emergency interventions have the potential for (re)traumatizing such individuals. Further, we recognize that despite best intentions, decisions concerning the use of seclusion and restraint are necessarily made under less than ideal circumstances (i.e., emergencies), and involve the urgent weighing of significant risks versus the benefits of physical safety. Therefore, such emergency interventions as the use of seclusion and restraints are to be avoided wherever possible. As part of this commitment, leadership explicitly espouses the following principles and values in regard to seclusion and restraints:

(A) Use of Seclusion and/or Restraint is seen as a safety intervention of last resort, rather than a treatment intervention *per se,* and its usage should be an uncommon event;

(B) An organizational philosophy of giving the highest priority to all non-violence is to be articulated in all policies, procedures and practices;

(C) Individuals are to have a voice in determining treatment options;

(D) Practices that are sensitive to those with a history of trauma are to be in place;

(E) Key models are to be identified that support a culture of individual empowerment and recovery that is supportive, compassionate and non-punitive; and

(F) An environment of care is to be created that is welcoming and attractive and adaptable as possible

(4) Therefore, restraint and seclusion shall be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible. Non-physical interventions are the first choice as an intervention unless safety issues demand immediate physical intervention. The facility's approved early intervention crisis prevention techniques will be used to de-escalate conflict when possible. Restraint/seclusion shall not be used for the purposes of discipline, the convenience of staff, as a substitute for a program, as a replacement for adequate levels of staff, or as punishment, or as the sole basis for transfer from an inpatient psychiatric facility to a more secure psychiatric setting. The dignity, privacy and safety of individuals who are restrained or secluded should be preserved to the greatest extent possible during the use of these interventions. Seclusion and restraint should be initiated only in those individual situations in which an emergency

safety need is identified, and these interventions should be implemented only by competent, trained staff.

(5) The following shall apply to any use of physical or mechanical restraints or seclusion:
(A) Only approved techniques for physical or mechanical restraints are used;
(B) Instances in which physical, mechanical restraint or seclusion is used are documented on appropriate facility forms;
(C) Standing or PRN order shall not be used.
(D) Restraints shall not be used as a means of coercion, as discipline or punishment, for the convenience of staff, as retaliation by staff, as a substitute for treatment or rehabilitation programming, or used in a manner that causes undue physical discomfort or pain to the individual; and
(E) Intentional use of a restraint technique or any excess application of force shall be considered abuse and is cause for disciplinary action against the employee.

(6) As used in this DOR, the following terms mean:
(A) "Seclusion" is the involuntary confinement of a person alone in a room, where the person is physically prevented from leaving.
(B) “Restraint” is any involuntary method of physically restricting a person’s freedom of movement, physical activity, or normal access to his or her body.
1. For the purpose of this definition, restraint includes:
A. A physical restraint - Any manual method/therapeutic hold or physical or mechanical device, material, or equipment attached or adjacent to the individual’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one’s body. This includes usage of mechanical restraints in which the person is either ambulatory or non-ambulatory.
B. A chemical restraint – Any drug used to control behavior or to restrict the person’s freedom of movement which is not a recognized treatment for the person’s medical or psychiatric condition. Additionally, chemical restraint is considered an inappropriate method of controlling behavior and is not the practice of any facility in the Department of Mental Health. Use of a medication is considered inappropriate if: (a) it is not a recognized treatment for the individual’s mental disorder; or (b) the medication is administered excessively, such that it can be expected to produce sedation or limit the individual’s ability to participate in the treatment process rather than treat symptoms of the mental disorder. However, medication may be used appropriately to treat behavioral symptoms of mental disorder, including aggressive behavior, and in that case, the specific medication use shall be included in the treatment plan and shall not be considered chemical restraint.
2. For the purposes of this definition, restraint does NOT include:

A. A therapeutic hold from which an individual can easily break away; OR
B. Physical redirection that continues to provide the individual the opportunity for independent movement in more than one direction (e.g., use of approved techniques for the management of physical aggression to either block a blow OR a therapeutic hold that prevents an individual from striking another person, provided that the individual is still able to move independently in other directions).
C. Mechanical devices that provide an individual postural support.

(C) "Trained staff", such persons designated by facility policy who have been approved, tested, and recognized as competent to provide one of the following services:

1. All direct care staff and other staff involved in the use of restraint and seclusion including causes, related medical conditions, impact of staff behavior, de-escalation, recognizing physical distress, and an individual's viewpoints regarding its use.
2. Those who apply the restraint receive the above and demonstrate the safe use of restraint including; physical hold techniques, take-down procedure, and the application and removal of mechanical restraints.
3. Those authorized to provide 15-Minute assessment are competent as above and demonstrate competence in: taking and interpreting vitals, checking circulation and range of motion, signs of incorrect application of restraints, addressing hygiene and elimination needs, recognizing nutritional/hydration needs, addressing physical and psychological status, recognizing signs of potential readiness for discontinuation, assisting the individual to meet the behavioral criteria for discontinuation, and recognizing the need to contact medical personnel for further evaluation.
4. The assigned RN will be competent in the above and demonstrate competence in assessing physical, and psychological status, and assessing for discontinuation.
5. Persons authorizing restraint or seclusion in emergency situations and/or determining the need to secure a new order, are competent as above, are a licensed registered nurse, and have demonstrated competence in; recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the individual's reactions, and using behavioral criteria for discontinuing restraint/seclusion and assisting individuals in meeting these criteria.

(D) "Physician," responsible psychiatrist, on call physician, officer of the day, treatment team physician and other designated licensed physicians clinically privileged to perform the functions as physicians as set out in this DOR.

(E) Time out," temporary exclusion or removal of an individual from positive reinforcement. It is a behavior modification procedure in which, contingent upon the individual's emission of undesired behavior, the individual is removed from the situation that affords positive reinforcement.

(7) Each facility shall include in its policies the proper use and maintenance of restraint and seclusion equipment.

(8) Each facility shall collect from individuals, at the time of admission to the facility, information that will assist in preventing the use of restraint or seclusion or in minimizing the extent of their use. This process will include:
(A) Administration of an instrument chosen by the facility to collect information about the individual's history of exposure to sexually, physically or emotionally traumatic events, or other trauma – including trauma from previous use of seclusion and restraints or other prior mental health interventions;
(B) Staff should discuss with each individual strategies to both identify and reduce the specific precursors of violent behavior (e.g., agitation, anger, hostility, impulsivity, etc.) that might ultimately lead to the use of seclusion and restraint; such discussion shall include what kind(s) of treatment or intervention would be most helpful and least traumatic for the individual.
(C) Use of an instrument or form that collects systematic information about stimuli or situations that typically increase the individual's degree of agitation, activities or interventions that are typically calming when the individual is agitated, and the individual's history of restraint or seclusion in psychiatric settings; and
(D) Designation of a family member or other person the individual wishes to be informed if restraint or seclusion is used. This information will be used in the development of the individual's treatment plan.
(E) A method for reviewing and updating this information for any individual whose length of stay exceeds twelve (12) months.
(F) History of violent acts committed by the individual.

(9) While it may be necessary to initiate restraint or seclusion when the treating physician is not physically present, it is desirable that any application of restraint or seclusion be supervised by a responsible physician to the greatest degree possible. The responsible physician should be notified at the earliest time possible when a situation has a significant likelihood of leading to restraint or seclusion, but no later than 1 hour after the initiation of seclusion or restraint. When notified of such a situation, the physician should come personally to evaluate the situation as soon as is reasonably possible. Once the physician is physically present, he or she will assume leadership responsibility and direct the other clinical staff in managing the individual's behavior.

(10) Each facility will develop a procedure by which a member of the clinical executive/management leadership is notified as soon as is practically possible in the event that seclusion or restraint is used. The clinical executive will review the situation with the clinical staff members involved, and there will be a discussion that explores alternative strategies that might have been used. A report by the

clinical executive will form part of the documentation of the episode of restraint or seclusion.

(11) Procedures for restraint or seclusion include the following.

(A) Use of seclusion or restraint shall cease when the circumstance causing the need for the procedures have ended.

(B) A physician, or his/her APN designee, may authorize a registered nurse to use seclusion or restraint to control an individual's dangerous behavior with a written order. Emergency measures are described in section 11.

1. A physician, or his/her APN designee, shall conduct a face to face clinical assessment of the individual before signing an order authorizing the use of physical or mechanical restraints.
2. The written orders/documentation in the individual's record shall contain at least the following information:
   A. Behavior demonstrated necessitating restraint/seclusion;
   B. Alternative interventions attempted that failed;
   C. Rationale for the type of restraint/seclusion selected;
   D. Behavioral criteria for the individual's release;
   E. Methods for staff to use to assist individuals in regaining control;
   F. Consideration of any pre-existing medical conditions that might be exacerbated by restraint or seclusion; and
   G. Assessment for physical injury.

(C) Each order for seclusion or restraint shall be time limited and shall not exceed 4-hours for adults, 2 hours for children and youth 9 to 17 and 1 hour for children under 9.

1. By the time the order for restraint or seclusion expires, a face-to-face evaluation of the individual is conducted by the physician responsible for the individual's care, his/her APN designee, another physician or his/her APN designee, or a qualified, trained individual (a Registered Nurse) authorized by the hospital to perform this function.
2. In conjunction with the individual's reevaluation, a new written or verbal order is given by the physician, or his/her APN designee, if the restraint or seclusion is to be continued. This new order is also time limited, and shall not exceed 4-hours for adults, 2 hours for children and youth 9 to 17 and 1 hour for children under 9.
3. The physician, or his/her APN designee, conducts a face-to-face reevaluation at least every 8 hours for individuals ages 18 years and older and every 4 hours for individuals ages 17 and younger.

(D) Notification of clinical leaders is required when seclusion or restraint is used in any of the following circumstances:

1. Any episode that lasts 12 consecutive hours;

2. Any two or more episodes within a 12 consecutive hour period; and
3. Any episode which continues beyond 24 consecutive hours, with provisions for continued notice for every 24 hour period thereafter.

(E) Facility policy is to specify the mechanisms for notification and any authorization required from clinical leadership. A physician, or his/her APN designee, shall observe the individual, assess the necessity for continued physical or mechanical restraints and provide documentation in the progress notes. He/she shall provide written orders for each additional 24 hours of physical or mechanical restraints after providing notice to clinical leadership. All of the conditions set out in this section also apply to new physical or mechanical restraint orders.

(F) While individuals are in restraints or seclusion, trained staff shall -

1. Observe and assess the individual continuously, to assure appropriate care and treatment including bathing, intake of fluids, regular meals, exercise and use of toilet;
2. During observation, if it is believed that the individual's dangerous behavior has ceased, the observer will immediately notify a registered nurse who will verify observation;
3. Observations under paragraphs 1 and 2 shall be documented per facility approved flow sheet; and, An R.N. shall assess the individual and document at least every hour.

(G) When a restraint involves a physical hold, a second staff person is assigned to observe the individual.

(H) When restraint or seclusion is ordered for an individual, the physician, or his/her APN designee, ordering the restraint or seclusion will consult as soon as possible with the physician providing ongoing care to the individual. The consultation is to be documented in the progress notes.

(12) In an emergency (i.e. imminent danger or reasonable likelihood of serious physical harm to self/others) trained staff may initiate the physical or mechanical restraint of an individual or placement of the individual in seclusion..

(A) The registered nurse approved per facility policy to sanction restraint or seclusion procedures shall observe and assess the individual immediately and document the following in the progress notes:

1. The necessity for physical or mechanical restraint or seclusion, and inadequacy of less restrictive intervention and what interventions have already been attempted;
2. The type of physical or mechanical restraint or seclusion;
3. The expected behavior necessary for release from physical or mechanical restraint or seclusion; and
4. The physical condition of the individual prior to the use of mechanical restraint or seclusion.

(B) Until a physician, or his/her APN designee, is reached for an order, individuals may be mechanically restrained or secluded under sanction from a registered

nurse. The registered nurse who sanctioned the restraint or seclusion shall document the phone/verbal order on an emergency use basis. The period prior to the order shall be as brief as possible and should not exceed one (1) hour.

(C) A physician, or his/her APN designee, shall conduct a face-to-face clinical assessment of the individual within one hour of the verbal order initiating seclusion or restraints and enter a written order authorizing the restraint or seclusion in the individual's record at the time assessment as delineated in 11B2 is completed.

(D) Registered nurse documentation shall proceed according to the facility policy, including the following:

1. When procedure is initiated;
2. Every hour while in restraints or seclusion;
3. Upon release from seclusion or restraint; and
4. Upon notification the individual's dangerous condition appears to have ceased.

(13) All staff who implement written orders for restraint or seclusion shall have documented annual training and be certified in the proper use of the procedure for which order was written.

(14) The following steps shall be taken to reduce the likelihood of re-occurrence of the use of physical or mechanical restraint or seclusion:

(A) A debriefing with staff members involved in the application shall take place immediately following the procedure in order to determine:

1. Any improvements that could be made to reduce the likelihood of reapplication;
2. Any improvements in the procedure that could have made the event less traumatic; and
3. Assess any trauma reactions on the part of the staff.

(B) Facility Leadership will review debriefing reports of seclusion or restraint incidents at regular intervals to ensure that every effort was made to avoid the application. Furthermore, in its review leadership will assess the extent to which the individual's physical and psychological well being were cared for and the potential for traumatization was minimized. Areas for improvement identified through such reviews will be conveyed to the individual's treatment team.

(C) Upon application, there will be a written modification to the treatment plan to reflect the use of restraint or seclusion and to identify methods of reducing the likelihood of reoccurrence.

(D) As soon as possible, but no later than 24 hours after the incident, a debriefing will take place (including the family as appropriate) in order to:

1. Identify what led to the incident and what could be done differently;

2. Ascertain that the individual's physical well-being, psychological comfort and right to privacy were addressed; and
3. Counsel the individual for any trauma.

(E) The individual's treatment team will review modification to the treatment plan made during the incident and develop a permanent plan for dealing with the issues which led to the seclusion or restraint.

(15) The medical staff through the Quality Management Office for that facility is responsible for the risk management issues regarding seclusion or restraint. These shall include, but not be limited to, the following:

(A) Identify and report when seclusion or restraint is used longer than 12 hours or when 2 or more incidents happen in any 12 hour period;

(B) Identify and report all unusual or possible unwarranted patterns of utilization including but not limited to trends in shift, initiating staff, episode length, date and time, day of the week, type, injuries to individuals or staff, the individual's age, and individual's gender;

(C) Identify and report facility utilization of seclusion or restraint at periodic intervals, but not less than quarterly;

(D) Annually review facility policies, procedures and training programs and recommend necessary changes to the facility head; and .

(E) Identify and approve physical restraint procedures for use in the facility.

(16) Facility executive committees will maintain continuous efforts to reduce the use of seclusion and restraint and traumatic effects associated with their application by prominently reflecting such efforts in strategic initiatives and performance improvement processes.

*History: Original DOR Effective December 1, 1983. Amendment effective February 8, 1984. Amendment effective February 1, 1994. Amendment effective July 1, 2002. On July 1, 2003 the sunset date was extended to July 1, 2004. On July 1, 2004 the sunset date was extended to July 1, 2005. Amendment effective July 1, 2005.*